HEALTH INSURANCE AND
WORKER'S COMPENSATION INFORMATION & AUTHORIZATION

PAYMENT POLICY:
Our commitment is to provide you with the best possible care. In order to do this, we need your assistance and understanding of our payment policy so that billing and collection costs are minimized.

HEALTH INSURANCE:
If your health insurance is one that we **participate with,** you are responsible for a specified deductible and/or co-payment or co-insurance, as determined by your insurance company. Co-payments are due at time of treatment. Payment for several treatments may be made in advance if you so desire. Co-insurance will be billed to you after your insurance has made payment. If your insurance company denies payment, you will be held responsible for the entire amount of the bill. **Deductible** is collected at each visit until it is met. The patient will be notifies once deductible is met. If the patient overpays the deductible amount, **RESULTS PHYSCIAL THERAPY Inc.** will reimburse the patient. **For patients without insurance, the initial evaluation is $155.00 and follow-up visits are $120.00.** These amounts are determined based on average reimbursement.

WORKER'S COMPENSATION:
We will file a claim with your employer's worker's compensation carrier upon your request and after you have initiated a claim for same. We must be provided with the necessary information. If your claim is denied, you will be held responsible for the entire amount of the bill.

CANCELLATION POLICY:
Please notify us 24 hours in advance if you are unable to keep a scheduled appointment, otherwise the charge for the missed appointment will be **$50.00 (payable by you at your next visit).** You may call to leave a message at any time.

With your signature, you agree to adhere to the above payment policy. Failure to adhere to payment policy does not in any way modify or waive the payment policy. In the event that **RESULTS PHYSICAL THERAPY INC.** retains an attorney and/or collection agency to collect any unpaid balance of your bill, then by your signature to this document you agree to pay all costs of collection including collection fees, attorney fees in the amount of 1/3 of the principal balance in default, court costs, and other reasonable and related costs.

By my signature below, I hereby authorize **RESULTS PHYSICAL THERAPY INC.** to apply for benefits to my insurance plan on my behalf for covered services rendered by same and request that payment be made directly to Results Physical Therapy Inc. I certify that the information I have reported with regard to insurance coverage is correct. I further authorize the release of any necessary information including medical information for this or any related claim. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me in writing at any time.

I HAVE READ AND UNDERSTAND THE FOREGOING STATEMENTS

SIGNED_____ **DATE**_____

PRINT PATIENT's NAME: _____